IDENTIFYING DATA

Potential Claimant(s)_____

Date of Incident Drop down Box

SCOPE OF EMPLOYMENT STATEMENT

I, the undersigned, on Drop Down Box (Date) authorized _____ (Name)

_____
(Grade, SSAN, Unit, Unit's Address, Residence Address, or)
(Position, Unit by which employed, Unit Address, Residence Address)

to operate government vehicle_____ (Type, Serial Number) on Drop down Box (Date)

with the specific mission of_____
(Explain in detail)

The starting point was_____ and the time of departure was at_____ hours on_____. The normal time required for the trip is_____ hours and the actual route of travel was from _____
(Give Itinerary)
_____. In my opinion the route taken was most direct and practicable under the circumstances.

Check Box to be able to Select all if needed

The National Guard member(s) were engaged at the time of incident in:

_____ Inactive Duty Training under Title 32 USC 502.
_____ Annual Field Training under Title 32 USC 503.
_____ FTTD AFTM/CFTM Program under Title 32 USC 503.
_____ FTTD National Guard School under Title 32 USC 504.
_____ FTTD Recruiting Duty under Title 32 USC 505.
_____ AGR Full Time Recruiting under Title 32 USC 503.
_____ National Guard Technician acting in the scope of his employment under Title 32 USC 709a.
_____ Active Component FTM under Title 10.

_____
(Name and Grade)

_____
(Position)

_____
(Organization)

_____
(Address)

SURVIVOR BENEFIT PLAN, PUBLIC LAW 95-397

STATEMENT OF INTENT

Check Box opt.

Option A	☐	**I decline to make an election at this time. I will remain eligible to make an election for coverage at age 60.**
Option B	☐	**I elect to provide an annuity beginning on my 60th birthday if I die before that date, or on the date of death if I die after my 60th birthday.**
Option C	☐	**I elect immediate annuity starting the date of my death, whatever my age at death.**

Drop Down Box
(Date)

(Signature of Service Member)

(Signature of Witness)

(Signature of Member's Spouse)

SDNG FORM 39-● (29 Jun 92)

SOUTH DAKOTA ARMY NATIONAL GUARD

MEDICAL SERVICE INVOICE

Medical Facility:		Fax:	
Address:		Med Facility POC:	
City, State, ZIP		Tax ID:	
Phone:			

Soldier's Name:		SSN:	
Unit:		UIC:	
Rank:		DOB:	

The above named soldier is authorized the below indicated medical service:

AUTHORIZED SERVICE	COST
	$

TOTAL: $ _____

Return this completed Medical Services Invoice along with bill to: SDARNG, ATTN: SD-DCSPER-HSS, 2823 West Main Street, Rapid City, SD 57702-8186.

_____ _____

Signature of Unit Representative — Signature of Medical Facility Representative

SDNG FORM 40 (Jun06)

MEDICAL SERVICE INVOICE - Under Age 38
AUTHORIZATION FOR NATIONAL GUARD MEDICAL SERVICES/EXAMINATION

Section I - To be completed by individual's unit

Check Box
Check One - ☐ Appointment ☐ Enlistment ☐ OCS ☐ Reenlistment

Unit:	Health Care Provider/Facility:
POC:	Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Phone:	Phone:
UIC:	POC:

Grade/Name/SSN of soldier to receive Medical Services:

_____

Section II - To be completed by Health Care Provider

The above named individual is authorized to receive medical services at Federal Expense (Credit Card Payment) in accordance with the requirements of NGR 40-501. Payment is authorized for the following:

Date of Medical Services: Drop Down Box

SERVICE	ACTUAL CHARGE
Medical Examination including Urinalysis.....	
Serology (RPR).....	
Electrocardiogram with Interpretation.....	
Audiometer.....	
Cholesterol,.....	
Total Charges	

INSTRUCTION TO HEALTH CARE PROVIDER: Return this completed form along with invoice for service and documentation of service (completed physical) to the unit listed above. Unit will forward all documents to the SDARNG Health Services Office. At that time, a representative from the Health Services Office will contact the Health Care Provider and make arrangements for credit card payment.

Electronic Signature Date Drop Down
Signature of Authorized Unit Representative
Signature constitutes commitment of Federal Funds

Electronic Signature Date Drop Down Box
Signature of Health Care Provider/Billing Administrator as appropriate

TAX ID NUMBER: _____

HEALTH CARE PROVIDER MUST COMPLETE, SIGN AND RETURN ALONG WITH INVOICE AND DOCUMENTATION OF SERVICE (COMPLETE PHYSICAL) FOR AUTHORIZATION OF PAYMENT.

SDNG Form 40-1[redacted] 1 APR 00 Previous editions are obsolete and will not be used

MEDICAL SERVICE INVOICE - Age 38 and Over
AUTHORIZATION FOR NATIONAL GUARD MEDICAL SERVICES/EXAMINATION

Section I - To be completed by individual's unit

Check Box
Check One ☐ Appointed ☐ Enlisted ☐ Reenlisted

Unit:	Health Care Provider/Facility:
POC:	Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Phone:	Phone:
UIC:	POC:

Grade/Name/SSN of soldier to receive Medical Services:

Section II - To be completed by Health Care Provider

The above named individual is authorized to receive medical services at Federal Expense (Credit Card Payment) in accordance with the requirements of NGR 40-501. Payment is authorized for the following:

Date of Medical Services: Drop Down Box

SERVICE	ACTUAL CHARGE
Medical Examination including Urinalysis.....	
Serology.....	
Electrocardiogram with Interpretation.....	
Audiometer.....	
Cholesterol, HDL and Blood Sugar.....	
Intraocular Tension (Tonometry).....	
Total Charges	

INSTRUCTION TO HEALTH CARE PROVIDER: Return this completed form along with invoice for service and documentation of service (completed physical) to the unit listed above. Unit will forward all documents to the SDARNG Health Services Office. At that time, a representative from the Health Services Office will contact the Health Care Provider and make arrangements for credit card payment.

Electronic Signature Date Dropdown Box
Signature of Authorized Unit Representative
Signature constitutes commitment of Federal Funds

Electronic Signature Date Drop Down Box
Signature of Health Care Provider/Billing
Administrator as appropriate

TAX ID NUMBER: _____

HEALTH CARE PROVIDER MUST COMPLETE, SIGN AND RETURN ALONG WITH INVOICE AND DOCUMENTATION OF SERVICE (COMPLETE PHYSICAL) FOR AUTHORIZATION OF PAYMENT.

SDNG Form 40-2 1 APR 00 Previous editions are obsolete and will not be used

MEDICAL SERVICE INVOICE - Under Age 38
AUTHORIZATION FOR NATIONAL GUARD MEDICAL SERVICES/EXAMINATION

Section I - To be completed by individual's unit

PERIODIC

Unit:	Health Care Provider/Facility:
POC:	Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Phone:	Phone:
UIC:	POC:

Grade/Name/SSN of soldier to receive Medical Services: _____

Section II - To be completed by Health Care Provider

The above named individual is authorized to receive medical services at Federal Expense (Credit Card Payment) in accordance with the requirements of NGR 40-501. Payment is authorized for the following:

Date of Medical Services: Drop Down Box

SERVICE	ACTUAL CHARGE
Medical Examination including Urinalysis....	
Audiometer.....	
Cholesterol,.....	
Total Charges	

INSTRUCTION TO HEALTH CARE PROVIDER: Return this completed form along with invoice for service and documentation of service (completed physical) to the unit listed above. Unit will forward all documents to the SDARNG Health Services Office. At that time, a representative from the Health Services Office will contact the Health Care Provider and make arrangements for credit card payment.

Electronic Signature Date Drop Down Box

Signature of Authorized Unit Representative
Signature constitutes commitment of Federal Funds

Electronic Signature Date Drop Down Box

Signature of Health Care Provider/Billing
Administrator as appropriate

TAX ID NUMBER: _____

HEALTH CARE PROVIDER MUST COMPLETE, SIGN AND RETURN ALONG WITH INVOICE AND DOCUMENTATION OF SERVICE (COMPLETE PHYSICAL) FOR AUTHORIZATION OF PAYMENT.

SDNG Form 40-3[redacted] 1 APR 00

Previous editions are obsolete and will not be used

MEDICAL SERVICE INVOICE - Age 38 and Over
AUTHORIZATION FOR NATIONAL GUARD MEDICAL SERVICES/EXAMINATION

Section I - To be completed by individual's unit

PERIODIC

Unit:	Health Care Provider/Facility:
POC:	Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Phone:	Phone:
UIC:	POC:

Grade/Name/SSN of soldier to receive Medical Services:

Section II - To be completed by Health Care Provider

The above named individual is authorized to receive medical services at Federal Expense (Credit Card Payment) in accordance with the requirements of NGR 40-501. Payment is authorized for the following services:

Date of Medical Services: Drop Down Box

SERVICE	ACTUAL CHARGE
Medical Examination including Urinalysis....	
Audiometer.....	
Electrocardiogram with Interpretation.....	
Intraocular Tension (Tonometry).....	
Cholesterol, HDL and Blood Sugar.....	
Total Charges	

INSTRUCTIONS TO HEALTH CARE PROVIDER: Return this completed form along with invoice for service and documentation of service (completed physical) to the unit listed above. Unit will forward all documents to the SDARNG Health Services Office. At that time, a representative from the Health Services Office will contact the Health Care Provider and make arrangements for credit card payment.

Electronic Signature Date Drop Down Box
Signature of Authorized Unit Repesentative
nature constitutes commitment of Federal Funds

Electronic Signature Date Drop Down Box
Signature of Health Care Provider/Billing
Administrator as appropriate

TAX ID NUMBER: _____

HEALTH CARE PROVIDER MUST COMPLETE, SIGN AND RETURN ALONG WITH INVOICE AND DOCUMENTATION OF SERVICE (COMPLETE PHYSICAL) FOR AUTHORIZATION OF PAYMENT.

SDNG Form 40-4[redacted] 1 APR 00

Previous editions are obsolete and will not be used

MEDICAL SERVICES INVOICE
AUTHORIZATION FOR NATIONAL GUARD MEDICAL SERVICE/EXAMINATION

Section I - To be completed by individual's unit

Panographic X-Ray

Unit:	Health Care Provider/Facility:
POC:	Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Phone:	Phone:
UIC:	POC:

Grade/Name/SSN of soldier to receive Dental Services:

_____

Section II - to be completed by Health Care Provider

The above named individual is authorized to receive Dental Services at Federal Expense (Credit Card Payment) in accordance with the requirements of NBR 40-501. Payment is authorized for the following services:

Date of Dental Services: Drop Down Box

SERVICE	ACTUAL CHARGE
Panographic X-Ray	
Total Charges	

Copy of X-Ray NOT AUTHORIZED unless prior TAGO approval granted!
APPROVAL GRANTED BY: Electronic Signature **Date** Drop Down Box

INSTRUCTIONS TO HEALTH CARE PROVIDER: Return this completed form along with invoice for service and documentation of service and Panographic X-Ray to the unit listed above. Unit will forward all documents to the SDARNG Health Services Office. At that time, a representative from the Health Services Office will contact the Health Care Provider and make arrangements for credit card payment.

Electronic Signature Date Drop Down Box

Signature of Authorized Unit Representative
Signature constitutes commitment of Federal Funds

Electronic Signature Date Drop Down Box

Signature of Health Care Provider/ Billing Administrator as appropriate

TAX ID NUMBER: _____

HEALTH CARE PROVIDER MUST COMPLETE, SIGN AND RETURN ALONG WITH INVOICE AND DOCUMENTATION OF SERVICE (COMPLETED PHYSICAL) FOR AUTHORIZATION OF PAYMENT.

MEDICAL SERVICE INVOICE
AUTHORIZATION FOR NATIONAL GUARD MEDICAL SERVICES/EXAMINATION

Section I - To be completed by individual's unit

Cardiovascular Phase II Screening (Treadmill Stress Test)

Unit:	Health Care Provider/Facility:
POC:	Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Phone:	Phone:
UIC:	POC:

Grade/Name/SSN of soldier to receive Medical Service: _____

Section II - To be completed by Health Care Provider

The above named individual is authorized to receive medical services at Federal Expense (Credit Card Payment) in accordance with the requirements of NGR 40-501. Payment is authorized for the following services:

Date of Medical Services: Drop Down Box

SERVICE	ACTUAL CHARGE
Treadmill Stress Test with Interpretation	
Total Charges	

NOTE: Payment is authorized only for the Treadmill Stress Test. More advanced testing requires prior approval from the SDARNG Health Service Office.

INSTRUCTIONS TO HEALTH CARE PROVIDER: Return this completed form along with invoice for service and documentation of service (Stress Test w/interpretation) to unit listed above
Unit will forward all documents to the SDARNG Health Service Office. At that time, a representative from the Health Services Office will contact the Health Care Provider and make arrangements for credit card payment.

Electronic Signature Date Drop Down Box

Signature of Authorized Unit Representative
Signature constitutes commitment of Federal Funds

Electronic Signature Date Drop Down B

Signature of Health Care Provider/Billing

TAX ID NUMBER: _____

EALTH CARE PROVIDER MUST COMPLETE, SIGN AND RETURN ALONG WITH INVOICE AND DOCUMENTATION SERVICE (COMPLETE PHYSICAL) FOR AUTHORIZATION OF PAYMENT.

I have been provided information about the vaccination(s) I will receive today. I have had an oportunity to ask questions that were answered to my understanding. I believe I understand the benefits and risks of the vaccine(s).

Signature and Initials: _____

Drop Down

Drop Down

Date	Vaccine(s) given	Patient Initials	Date	Vaccine(s) given	Patient Initials

Rank _____
Name _____
D.O.B. _____
SSN _____

WORK SCHEDULE CHANGE

SSN:	NAME:	ACT UIC:	DIST:
EFFECTIVE DATE: Drop Down Box	T&A STATUS CODE:	AWS CODE:	

********** PAY PERIOD TOUR OF DUTY **********							
	SUN	MON	TUE	WED	THU	FRI	SAT
WEEK 1							
SHIFT							
NIGHT DIFF							

WEEK 2							
SHIFT							
NIGHT DIFF							

TIMECARD DESTINATION _____

Electronic Signature
AUTHORIZED SIGNATURE

Drop Down Box
DATE SUBMITTED

SDNG Form 43 (2 APR 95)

RESERVATION WORKSHEET

DATE: Drop Down Box Check Box PS NPS GNPS SP1 RECRUITER NAME AND GRADE: _____

BUDDY PLATOON

SSN _____ APPLICANT NAME (LAST FIRST MIDDLE) _____

Check Box CITIZENSHIP: YES | NO

Check Box SEX: M | F

Drop Down Box DATE OF BIRTH: DD MM YY

Drop Down Box ED YEARS

ED CODE

Check Box DRIVER'S LICENSE: YES | NO

PHYSICAL PROFILE

Check Box option

P	U	L	H	E	S	X

COLOR PERCEPTION: NOR_____ R/G_____ NON_____ RECRUITER ID: _____

AFQT	GT	GM	EL	CL	MM	SC	CO	FA	OF	ST

Check Box MATH

GEN	ALG	TRI	GEO

Check Box option SCIENCE

GEN	BIO	PHYS	CHEM

MSO ____/____/____

APPLICANT ADDRESS (STREET OR ROUTE) CITY STATE ZIP _____ APPLICANT PHONE NUMBER _____

DATE AVAILABLE FOR TNG: Drop Down Box

RETURN NLT

GRADE/RANK

PS/PMOS

MOS CHOICES

PARA LN	PARA LN	PARA LN

SRIP BENEFITS

SLRP	
2000	
1500	
AFFILIATION	

UNIT: _____ UIC: _____

ADDRESS: _____ PAYROLL # _____

CITY: _____ ZIP+4 _____

PHONE: _____

REMARKS

ENL OPTION:	6 X 2	4 X 4	3 X 5	MSO	OTHER

SDNG Form 45[illegible] (29 Jun 92)

Drop Down Box
(Date)

SUBJECT: Request for Pay and Certification of Individual Performance

USPFO for South Dakota
ATTN: [redacted] Military Pay Branch
2823 West Main Street
Rapid City SD 57702-8186

1. The following information relating to ADT/FTTD performance is hereby submitted:

NAME/GRADE	SSN	INCLUSIVE DATES	ORDER NO

2. Subject Service Members have reported for duty in accordance with appropriate orders and are due pay and allowances indicated. Individual authorized BAQ for primary dependents has executed or recertified DA Form 3298 and copy is on file. Changes affecting pay that accrues from this date to the ending date of the ordered duty will be immediately reported to the Military Pay Branch (MPB).

Electronic Signature
SIGNATURE OF UNIT COMMANDER/CERTIFYING OFFICER

SDNG Form 47[redacted] (29 Jun 92)

DISABILITY COUNSELING STATEMENT

I understand, to be eligible for continuance of pay and allowances while disabled from an injury/aggravation/illness/disease incurred in line of duty:

1. I must promptly notify my unit if in need of any medical or hospital care required as the result of this line of duty illness/injury.
2. I cannot seek private medical or hospital care without first requesting and receiving approval from my unit (the request will be processed by my unit for final approval through State Headquarters to NGB-ARP-H IAW NGR 40-3).
3. I must report for any medical appointment scheduled by my unit or by the doctor treating my condition.
4. I must cooperate fully with the medical personnel providing treatment and follow their course of treatment.
5. I must furnish to my unit, notification prior to each appointment, and upon completion of each of my medical appointments the documentation on the results of the appointment.
6. I must provide copies of my pay stubs if I work, receive sick, vacation pay, workmen's compensation or any monetary disbursement. This statement will include the amount received from each income protection plan/policy.
7. If I am employed during this period I must provide the following: Soldier's Claim Form – Employed (NGB Form 135-3-R).
   (1) Provide copies of my pay stubs.
   (2) Provide a statement as to whether I have one or more income protection plans and the amount of funds received from each, on a daily or monthly basis.
8. If I am self employed during this period I must provide the following: Soldier's Claim Form – Self Employed (NGB Form 135-5-r).
   (1) Provide a statement of income.
   (2) Provide a statement as to whether I have one or more income protection plans and the amount of funds received from each on a daily or monthly basis.
   (3) Provide a copy of my latest Internal Revenue Service tax forms to include Schedule "C" and all attachments.
9. If I am unemployed, I will provide a statement indicating I have not earned any income from any source. (Soldier's Claim Form – Unemployed – NGB Form 135-4-R).
10. Any money received by me from an insurance company (Third Party Claim) will be reported through channels to the State Judge Advocate.
11. I cannot expect any incapacitation benefits until my unit has received the approved Line of Duty. This may be six weeks after the investigation is initiated and forwarded from my unit. Questions regarding this Line of Duty will be addressed through my chain of command.
12. I understand I am not on active duty while incapacitated. I will not accrue leave nor receive active duty retirement points for the duration of this period and will not receive ADT/IDT/AT pay with incapacitation benefits.
13. I authorize and request the Veteran's Administration, my civilian physician, the civilian hospital providing my medical care, or any other facility providing care release any and all medical records, examinations, treatments, and summaries to my State Adjutant General and unit.

I understand that failure to fulfill the above requirements may result in termination of my entitlements to pay and allowances and medical care for this disability. The penalty for willfully making a false claim is a maximum fine of $10,000, imprisonment for 5 years, or both. (U.S. Code, Title 18, Section 287.1001)

DATE: _____ **SIGNATURE:** _____

NAME OF COUNSELOR: _____

DISTRIBUTION:
Original – Unit
Copy – Individual
Copy – Incap Pay Request
Copy – LOD Request
Review Annually – Complete new form when initiating LOD
SDNG FORM 50R dtd 10FEB00(replaces previous editions which are obsolete)

REVIEW DATE: _____

INTIALS: _____